STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF INDIANAPOLIS	7365 E 16TH ST INDIANAPOLIS, IN 46219

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R000000	This visit was for the Investigation of Complaint IN00153457. Complaint IN00153457 -- Substantiated. State residential deficiencies related to the allegations are cited at R296 and R349. Survey date: August 20 and 21, 2014 Facility number: 005729 Provider number: 005729 AIM number: N/A Survey team: Penny Marlatt, RN Census bed type: Residential: 64 Total: 64 Census Payor type: Medicaid: 61 Other: 3 Total: 64 Sample: 3 These state findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 25,	R000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	2014 by Cheryl Fielden, RN.			
R000296	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on interview and record review, the failed to ensure clearly written policies and procedures relating to assistance with medications to residents have been developed and implemented. This deficient practice has the potential to adversely affect all residents who are administered medications by facility staff. (54 of 63 residents) Findings include: During the initial tour on 8-20-14 between 9:05 a.m., and 9:35 a.m., with the Director of Health Services (DHS), she identified 63 residents who are current residents in the facility. Additionally, she identified 9 of the 63 residents who are assessed to be able to safely self administer their medications; the remaining 54 residents were identified to require assistance with medication administration from the nursing staff of the facility.	R000296	RE: R0296 Submission of this plan ofcorrection does not constitute admission of deficiency or admission ofguilt. All residents in the facility were at risk for the potential ofharm by such deficiency, no residents were found to have been harmed. In Regards to failureto provide written medication administration policy, our current policy hasbeen updated to include specific instructions on the documentation process formedication administration to include proper documentation when a resident'smedication is not given and an explanation as to why it was not given. Update includes the following: For allresidents who are unable to self-medicate, medication will be administered viaqualified staff. "All boxes on the MEDICATIONADMINISTRATION RECORDS SHEET(MARS) must be initialed, if a medication is notgiven the initialscorresponding with the time and date of said medication mustbe encircled. For each medication notgiven an	09/30/2014

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	In an interview with the DHS on 8-21-14 at 12:45 p.m., she indicated she was unsure what the facility's policy on documentation of medications was. She did not indicate any professional reference materials that were utilized by the facility for policy, procedure or concerns regarding any medications. She indicated she just utilized skills and knowledge she had learned from working in other nursing facilities. In interview with the Administrator on 8-21-14 at 2:30 p.m., she indicated the facility did not have a specific policy related to medication administration documentation. She indicated she would expect any medications that had encircled initials on a MAR would have an explanation written on the MAR or an accompanying nursing progress note. She indicated she has spoken to facility staff regarding "about making sure forms are filled out completely." On 8-21-14 at 3:45 p.m., the Administrator provided a copy of a policy entitled, "Medication Administration." This policy was indicated to be the current policy utilized by the facility. This policy indicated, "Residents of the facility shall received medications as ordered by their physicians to treat specific conditions...Should the resident		explanation is to be documented on theback of the MARS to include date,time, medication, reason not given andinitials of the staff person responsiblefor that particular medication pass"All QualifiedMedication Aides and All nurses have been inserviced on new documentationprotocol. Toensure that this process is completed a series of checks havebeen put intoplace. A rotating schedule of auditswill take place daily oneach shift. Anew Medication Administration Record Check off Sheet hasbeen created to enablethe staff to quickly check several records eachshift. The check off sheet is to be completed andgiven to the Director ofHealthCare Services or her designee at the end of eachDay. The Director of Healthcare Services or her designee withreview this sheet daily, if any issues are found the responsible staffperson will be contacted and instructed to return to the facilityimmediately to make any necessary documentation'. The Directorof Healthcare Services or her designee with perform a thorough audit of allMARS on a monthly basis to be completed prior to the 15th of the month for thepreceding month. To ensure that quality assurance is being obtained thisprocess will continue for no less than a period of 6 months, atwhich point the process will be reviewed for continuance. if thisquality	

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	be incapable to self-administer medications with or without reminders, a licensed nurse or qualified medications aide shall be expected to administer medications as ordered by the physician and document the same..." *Nursing Drug Guide, Nursing 2014*, indicated, "Medication errors are a significant cause of patient morbidity and mortality in the United States...Each institution must have tools and policies in place for the documentation of medication administration." This State tag relates to Complaint IN00153457. 5-6(b)		assurance program is successful, (if less than 10%of our clientalhave been affected) then this process will continue, if not the process will beupdated for greater success	
R000349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.			

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	Based on interview and record review, the facility failed to ensure clinical records accurately reflect medications administered, accurately reflect dates residents were present in the facility and medication administration records (MAR) have dates present on each record for 3 of 3 residents reviewed for medication administration in a sample of 3. (Resident #A, #B and #C) Findings include: 1. The clinical record of Resident #A was reviewed on 8-20-14 at 3:00 p.m. Her diagnoses included, but were not limited to, end-stage renal disease, hemodialysis, diabetes, hypertension, aortic stenosis, anemia and diabetic neuropathy. On 8-20-14 at 11:40 a.m., the Administrator provided a listing of residents who had been transferred or discharged from the facility for the last 90 days. Resident #A was indicated to have been transferred to an area hospital from 5-12-14 to 6-16-14; from 6-30-14 to 7-2-14 and 7-10-14 to 7-11-14. This listing indicated she discharged from the facility on 7-23-14 to an area health care facility. In review of the nursing progress notes	R000349	RE 0349 In Regards to failure to provide clinical records on eachresident that is complete, accurately documented, readily accessible, andsystematically organized . All residents in the facility were at risk forthe potential of harm by such deficiency, no residents were found to have beenharmed. For all residents who are admitted to our facility, orreadmitted to ourfacility. Medication Administration records will becompleted with resident name, name , title at date of staff responsiblefor admitting the resident The Director of Healthcare Services or herdesignee will complete a record check with in five days of admit toensure that the resident name, staff name, title of date of personcompleting admission is recorded on each page and that all records are completeand accurate. Allboxes on the MEDICATIONADMINISTRATION RECORDS SHEET (MARS) must be initialed,if a medication is notgiven the initials corresponding with the time and dateof said medication mustbe encircled. For each medication notgiven anexplanation is to be documented on the back of the MARS to includedate,time, medication, reason not given and initials of the staff personresponsiblefor that particular medication pass" All Qualified Medication Aides and All nurseshave been in	09/30/2014

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	for Resident #A, it indicated on 7-10-14 at 9:30 p.m. a phone call had been received from a family member which indicated the resident had been transferred to an area hospital from a doctor's appointment earlier in the day and had been admitted to the hospital. It indicated the family would contact the facility when the resident was to return to the facility. The next entry in the nursing progress notes, dated 7-31-14 at 10:00 a.m. indicated the resident had been discharged from the facility upon family request to an area health care facility. Review of Resident #A's MAR for June, 2014 indicated she was physician-ordered for the following medications and documentation of administration indicated the following information: -Sensipar 60 mg (milligrams) daily by mouth; give after dialysis on Tuesday, Thursday and Saturday. Blank administration blocks were indicated on 6-19-14 and 6-30-14. -Synthroid 75 micrograms by mouth daily; give after dialysis on Tuesday, Thursday and Saturday. Blank administration blocks were indicated on 6-19-14 and 6-30-14. Review of the back side of the MAR and the nursing progress notes did not indicate any explanations for the blank		servicedon new documentation protocol. To ensure that this process is completedaseries of checks have been put into place. A rotating schedule of auditswill take place daily on each shift. A new Medication AdministrationRecord Checkoff Sheet has been created to enable the staff to quickly checkseveral recordseach shift. The check off sheet is to becompleted andgiven to the Director of HealthCare Services at the end of eachshift. Toensure ongoing quality assurance the specific orientation training for newQMA's and LPN's will be updated to include specifics on the MAR Policy andproper documentation for admits and readmits	

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	administration blocks. Review of Resident #A's MAR for July, 2014 indicated she was physician-ordered for the following medications and documentation of administration indicated the following information: -simvastatin 10 mg by mouth every evening. The MAR indicated encircled staff initials (typically indicates medication was not administered) on administration blocks on 7-2-14, 7-3-14, 7-5-14, 7-6-14, 7-7-14 and 7-8-14. A blank administration block was indicated on 7-15-14. -Synthroid 75 micrograms by mouth daily at early morning. The MAR indicated encircled staff initials on administration blocks on 7-22-14 and 7-23-14. -Nephro caps one capsule daily by mouth; give after dialysis on Tuesday, Thursday and Saturday. The MAR indicated encircled staff initials on administration blocks on 7-4-14 A blank administration block was indicated on 7-11-14. Review of the back side of the MAR and the nursing progress notes did not indicate any explanations for why the medications were not administered or the blank administration blocks.			

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	Review of Resident #A's June, 2014 MAR forms indicated 1 of 7 pages did not have a month and year indicated. The portion of the form which indicated "Charting For/Through" and the portion which indicated, "Completed Entries Checked/By/Title/Date," were blank. 2. Resident #B's clinical record was reviewed on 8-20-14 at 1:40 p.m. Her diagnoses included, but were not limited to, Guillian-Barre syndrome, bilateral lower extremity edema and chronic kidney disease. Review of Resident #B's July, 2014 MAR indicated she was physician-ordered for the following medications and documentation of administration indicated the following information: -Lactulose 10 grams per each 15 milliliters (ml), give 15 ml or 10 grams by mouth twice daily by mouth. The MAR indicated encircled staff initials (typically indicates medication was not administered) on administration blocks for the evening doses on 7-1-14, 7-2-14, 7-3-14, 7-5-14, 7-6-14, 7-8-14, 7-10-14, 7-13-14, 7-14-14, 7-15-14, 7-16-14, 7-19-14, 7-20-14, 7-21-14, 7-22-14, 7-23-14, 7-24-14, 7-25-14 and 7-31-14. A blank administration block was indicated for the morning dose on			

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	7-26-14. -metformin 500 mg twice daily by mouth. A blank administration block was indicated for the morning dose on 7-26-14. -lisinopril 10 mg daily by mouth. A blank administration block was indicated on 7-26-14. -Coreg 3.125 mg twice daily by mouth. A blank administration block was indicated for the morning dose on 7-26-14. -Prilosec 20 mg daily by mouth. A blank administration block was indicated on 7-26-14. -Clonidine 0.1 mg three times daily by mouth. A blank administration block was indicated for the morning dose on 7-26-14. Review of the back side of the MAR and the nursing progress notes did not indicate any explanations for why the medications were not administered or the blank administration blocks. Review of Resident #B's August 1-21, 2014 MAR indicated she was physician-ordered for the following medications and documentation of administration indicated the following information: -Lactulose 10 grams per each 15 milliliters (ml), give 15 ml or 10 grams by mouth twice daily by mouth. The			

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	MAR indicated encircled staff initials (typically indicates medication was not administered) on administration blocks for the evening doses on 8-5-14, 8-6-14, 8-7-14, 8-8-14, 8-10-14, 8-11-14, 8-13-14, 8-14-14, 8-15-14, 8-16-14, 8-17-14, 8-18-14 and 8-19-14. -Colace 100 mg daily by mouth at bedtime. A blank administration block was indicated on 8-4-14. Review of the back side of the MAR and the nursing progress notes did not indicate any explanations for why the medications were not administered or the blank administration blocks. 3. Resident #C's clinical record was reviewed on 8-20-14 at 2:35 p.m. His diagnoses included, but were not limited to, chronic venous and deep vein thromboses and pulmonary emboli (blood clots), hypertension, depression, anxiety and pulmonary heart disease. On 8-20-14 at 11:40 a.m., the Administrator provided a listing of residents who had been transferred or discharged from the facility for the last 90 days. Resident #C was indicated to have been transferred to an area hospital from 7-9-14 to 7-22-14 and from 7-27-14 to 7-28-14. In review of the nursing progress notes			

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	for Resident #C, it indicated he was transferred to an area hospital on 7-9-14 at 7:16 p.m. and returned to the facility on 7-22-14 at 6:00 p.m. The progress notes indicated he was transferred to an area hospital on 7-24-14 at 5:00 p.m., and returned to the facility on 7-25-14 at 3:00 a.m. Review of Resident #C's MAR for July, 2014 indicated he was physician-ordered for the following medications and documentation of administration indicated the following information: -Flexeril 10 milligrams (mg) three times daily by mouth. Blank administration blocks were indicated on 7-28-14 for the noon dose and on 7-30-14 for the evening dose. -Bentyl 10 mg four times daily by mouth. Blank administration blocks were indicated on 7-28-14 for the noon dose and on 7-30-14 for the evening and bedtime doses. -Neurontin 600 mg twice daily by mouth. A blank administration block was indicated on 7-30-14 for the evening dose. -Hydralazine 50 mg three times daily by mouth. Blank administration blocks were indicated on 7-28-14 for the noon dose and on 7-30-14 for the bedtime dose. -metoprolol succinate 100 mg daily by			

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	mouth. The MAR indicated encircled staff initials (typically indicates medication was not administered) on an administration block for 7-23-14. Review of the back side of the MAR and the nursing progress notes did not indicate any explanations for why the medications were not administered or the blank administration blocks. Review of Resident #C's July, 2014 MAR forms indicated 6 of 6 pages did not have a month and year indicated. The portion of the form which indicated "Charting For/Through" as well and the portion which indicated, "Completed Entries Checked/By/Title/Date," were blank. In an interview with the Director of Health Services (DHS) on 8-21-14 at 12:45 p.m., she indicated she was unsure what the facility's policy on documentation of medications was. She did not indicate any professional reference materials that were utilized by the facility for policy, procedure or concerns regarding any medications. She indicated she just utilized skills and knowledge she had learned from working in other nursing facilities. The DHS indicated, "Whenever we have to handwrite the new orders or the monthly orders [recapitulation physician's orders],			

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	I just make sure the date is listed on the last page like it says on the form. Review of the recapitulation orders (physician's monthly orders) form utilized by the facility indicated, "See Physician Signature on Last Page." A statement regarding dating only the last page of the form was not located on the form. Review of the recapitulation orders (physician's monthly orders) form and the MAR form utilized by the facility indicated "Charting For/Through" and "Completed Entries Checked/By/Title/Date." Each form had a blank space for facility staff to enter appropriate dates. In interview with the Administrator on 8-21-14 at 2:30 p.m., she indicated the facility did not have a specific policy related to medication administration documentation. She indicated she would expect any medications that had encircled initials on a MAR would have an explanation written on the MAR or an accompanying nursing progress note. She indicated she has spoken to facility staff regarding "about making sure forms are filled out completely." On 8-21-14 at 3:45 p.m., the			

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	Administrator provided a copy of a policy entitled, "Medication Administration." This policy was indicated to be the current policy utilized by the facility. This policy indicated, "Residents of the facility shall received medications as ordered by their physicians to treat specific conditions...Should the resident be incapable to self-administer medications with or without reminders, a licensed nurse or qualified medications aide shall be expected to administer medications as ordered by the physician and document the same..." *Nursing Drug Guide, Nursing 2014*, indicated, "Medication errors are a significant cause of patient morbidity and mortality in the United States...Each institution must have tools and policies in place for the documentation of medication administration." This State tag relates to Complaint IN00153457. 5.8(1)(a) 5.8(1)(b)			